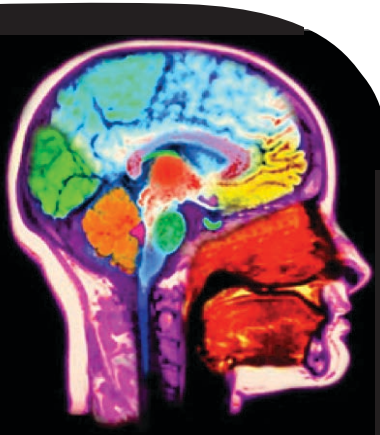
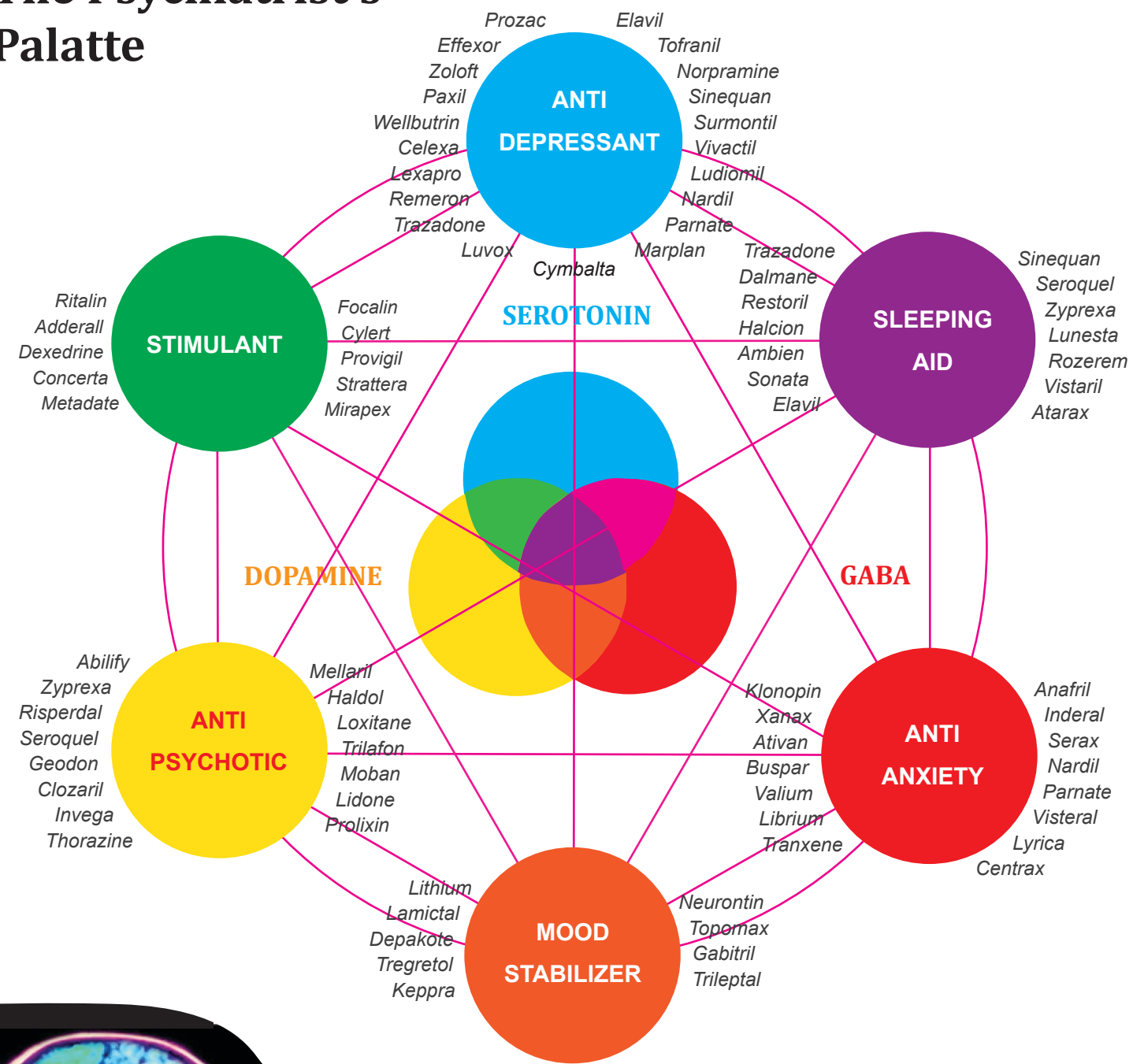
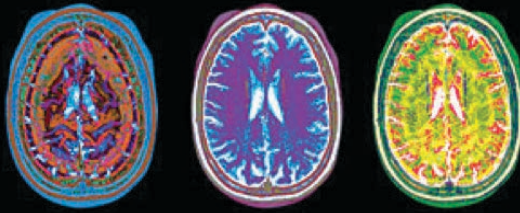


THE ART OF POLYPHARMACEUTICAL DIAGNOSTIC HONING

The Psychiatrist's Palatte



By skillful Pharmaceutical Augmentation, the patient's unique diagnostic image and medication blend can be layered gradually, ever more finely drawn, to arrive at the perfect mixture for lifetime treatment of complex mental illness --while optimally managing both patient compliance and side effects through quality-of-life and insurance coverage cost-benefit analysis.



- DYSTHYMIA
- ATYPICAL DEPRESSION
- MAJOR DEPRESSION
- PSYCHOTIC DEPRESSION
- BORDERLINE PERSONALITY
- PANIC DISORDER
- SOCIAL PHOBIA
- GENERALIZED ANXIETY
- OBSESSIVE-COMPULSIVE
- POST-TRAUMATIC STRESS
- BIPOLAR DEPRESSION
- BIPOLAR EUTHMIA
- BIPOLAR HYPOMANIA
- BIPOLAR MANIA
- SCHIZOPHRENIA
- ANOREXIA/BULIMIA
- ATTENTION DEFICIT/HYPER
- NO OTHER CLASSIFICATION

GRAYSCALE For Skillful Side Effects Management

- DEMENTIA
TARDIVE DYSKINESIA
- HEART DISEASE
- KIDNEY DISEASE
LIVER DISEASE
- DIABETES
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- CHRONIC PAIN
- OSTEOARTHRITIS
- REFLUX/INDIGESTION
- OBSIDITY

A patient's quality of life can be further enhanced by nutritional counselling and fitness programs for managing or controlling weight gain; Case managers can assist patient to apply for medicaid, disability benefits, housing assistance, and in some cases, employment.



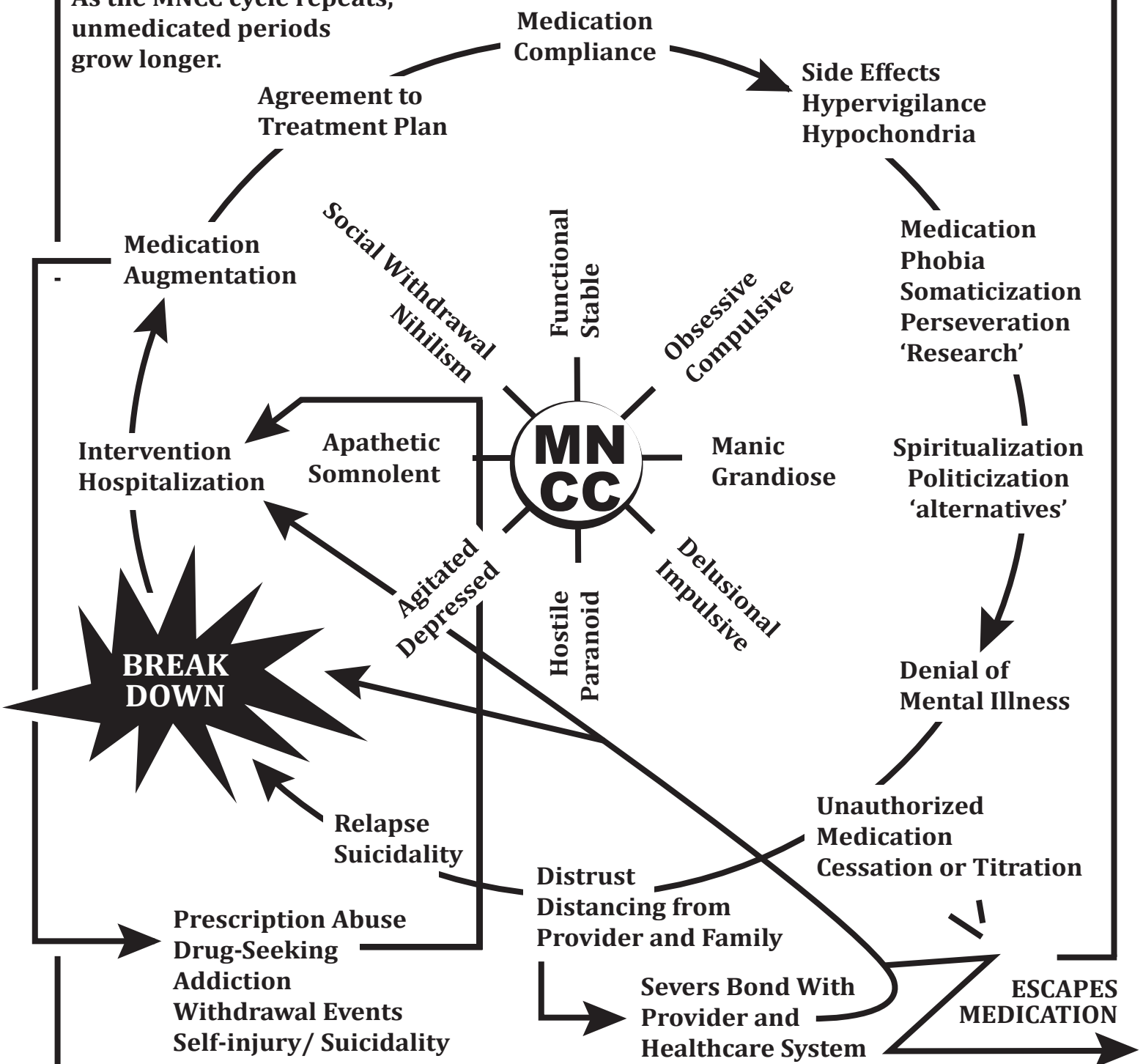


Polypharmacy Consortium representative Lydia Eccles emphasizes the importance of fighting the media-fueled stigma psychiatrists now face, which only exacerbates the ongoing crisis of undertreatment.

GUIDE TO MEDICATION NON-COMPLIANCE CYCLING

An Insight Tool for Health Providers, Patients and Families

As the MNCC cycle repeats, unmedicated periods grow longer.



THE SPECTRUM OF COMPLIANCE

Insight into biological mental illness
Willingly takes meds
Trusts Providers and family
 takes **Pride** in managing illness
Well-adapted to society and norms

tendency to **Self-blame**
 sometimes **Skips** meds
Changes Providers often
Difficulty managing illness
Apathy towards social system

Resists diagnosis
Refuses meds
Aborts treatment
Defiant embrace of symptoms
Alienated from social system

MEDICATION NON-COMPLIANCE CYCLING

**MN
CC**



Case Study: an abbreviated history

Female, age 60, never married, no children, part-time employment as bookkeeper, undergraduate degree, art school diploma. History of major depression, anxiety, alcoholism, substance abuse, eating disorders (binging), self-injury (cutting, burning), anxiety, phobias, promiscuity, poor self-care, hypergraphia, socio-culturally inappropriate behaviors and dependency upon family.

1972-1980 ~ (age 18-26): Alcoholism, bingeing, cutting, amphetamine overdose/ER, weight drops to 92 lbs.

Psychotherapy and group therapy; Diagnosis: eating disorder; Medications: none

1980 ~ Hospitalized for 5 months for self-harming and suicidality;

Psychotherapy; Diagnosis: chronic schizophrenic; Medications: Ludiomil, Thorazine, Navane

1981 ~ Stopped taking medications; left psychotherapy

1996 ~ Began attending 12-Step group, stopped drinking, stopped smoking.

1997 ~ Depressive breakdown (in care of sister)

begins psychotherapy 2X week (LICSW); diagnosis: major depression; medications: Paxil

2003 ~ Stopped taking medications (*duration unmedicated: 3 months*)

Depressive breakdown (in care of sister); ongoing psychotherapy; diagnosis: bipolar, depression; medications: Paxil, Lamictal.

2004 ~ Stopped taking medications (*duration unmedicated: 2.5 months*)

Depressive breakdown (in care of sister); ongoing psychotherapy; diagnosis: anxiety, bipolar, depression. medications: Lexapro (not tolerated), Welbutrin (not tolerated/hives), then Celexa; Lamictal, Klonopin.

Abused Klonopin, self-harm (burning), severe withdrawal episode.

2006-7 ~ Stopped taking medications (*duration unmedicated: 5 months*)

Depressive breakdown (in care of sister); ongoing psychotherapy, diagnosis: anxiety, bipolar, depression; medications: Celexa, Lamictal, Klonopin. Abused Klonopin, life-threatening withdrawal event (ER); ended relationship with psychotherapist (ending 7 years of treatment 2X week). Sister has "burned out" decides she can no longer care for her during breakdowns.

2007-8 ~ Stopped taking medications (*duration unmedicated: 9 months*)

Depressive breakdown (hospitalized 2 weeks, plus 2 week outpatient day program); psychotherapy at hospital; group therapy in outpatient program; diagnosis: borderline personality disorder, anxiety, bipolar, depression; medications: Cymbalta, Lamictal, Ativan, Seroquel. Following release sees 2 different LICSW for psychotherapy briefly.

2009-10 ~ Stopped taking medications

Depressive breakdown (to avoid hospitalization goes to 8-day live-in Kabat-Zinn stress-reduction mindfulness course); severely depressed, she spends two months seeking psychotherapist who will work with her without requiring medications. Begins psychotherapy 2X week with psychiatrist specializing in mindfulness; diagnosis: borderline, anxiety, bipolar, depression; medications: no daily meds but Klonopin for occasional "safety net" use only. Two months later, patient overdosed on Klonopin with self-injury.

2010 ~ Stopped taking all medications. (*duration unmedicated: 52 months to date*)

2014 ~ Psychotherapy ongoing 1X week; diagnosis: unknown; medications: none.

THE SPECTRUM OF COMPLIANCE

Patient trusts psychotherapist, but resists diagnosis, refuses medications, spiritualizes and politicizes her mental illness, and is maladapted to the social system. In colluding with the patient, psychiatrist is also non-compliant. Patient appears to have escaped medication. For now.